BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
VINCENT PAUL KATER, M.D.	)	Case No. 800-2015-010978
Physician's and Surgeon's Certificate No. G45851	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 31, 2019.

IT IS SO ORDERED November 27, 2018

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
Deputy Attorney General
State Bar No. 155553
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9405
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **VINCENT PAUL KATER, M.D.** **6719 Alvarado Road, Suite 305** **San Diego, CA 92120** **Physician's and Surgeon's Certificate No. G45851** Respondent.	Case No. 800-2015-010978 OAH No. 2018031101 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

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2. Vincent Paul Kater, M.D. (Respondent) is represented in this proceeding by Raymond J. McMahon, Esq., of Doyle Schafer McMahon whose address is 5440 Trabuco Road, Irvine, California 92620.

3. On or about August 12, 1981, the Board issued Physician's and Surgeon's Certificate No. G45851 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in First Amended Accusation No. 800-2015-010978 and will expire on April 30, 2019, unless renewed.

JURISDICTION

4. On January 11, 2018, Accusation No. 800-2015-010978 was filed before the Board. A true and correct copy of Accusation No. 800-2015-010978 and all other statutorily required documents were properly served on Respondent on January 11, 2018. Respondent timely filed his Notice of Defense contesting the Accusation

5. On February 12, 2018, First Amended Accusation No. 800-2015-010978 was filed before the Board and is currently pending against Respondent. A true and correct copy of First Amended Accusation No. 800-2015-010978, along with a true and correct copy of a Supplemental Statement to Respondent were properly served on Respondent on February 12, 2018. A true and correct copy of First Amended Accusation No. 800-2015-010978 is attached hereto as Exhibit A and incorporated by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in First Amended Accusation No. 800-2015-010978. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision;

and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in First Amended Accusation No. 800-2015-010978, a true and correct copy of which is attached hereto as Exhibit "A" and that he has thereby subjected his Physician's and Surgeon's Certificate No. G45851 to disciplinary action. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. G45851 for the Board's formal acceptance with an agreed upon effective date of January 31, 2019.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. G45851 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

11. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G45851, or petitions to revoke probation or if an First Amended Accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in First Amended Accusation No. 800-2015-010978 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California or elsewhere.

12. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. G45851 without further notice to, or opportunity to be heard by, respondent.

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CONTINGENCY

13. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

14. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

15. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, respondent will assert no claim that the

Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

16. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

17. The parties agree that copies of this Stipulated Surrender of License and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

18. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Medical Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order on behalf of the Board:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G45851, issued to Respondent Vincent Paul Kater, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order which shall be on January 31, 2019.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must

comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in First Amended Accusation No. 800-2015-010978 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in First Amended Accusation No. 800-2015-010978 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Raymond J. McMahon, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G45851. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/6/2018

VINCENT PAUL KATER, M.D.
Respondent

I have read and fully discussed with Respondent Vincent Paul Kater, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: November 6, 2018

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 11/6/2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2015-010978

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
MARTIN W. HAGAN
Deputy Attorney General
State Bar No. 155553
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9405
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **VINCENT PAUL KATER, M.D.** **6719 Alvarado Road, Ste. 305** **San Diego, California 92120** **Physician's and Surgeon's Certificate No. G 45851,** Respondent.	Case No. 800-2015-010978 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 12, 1981, the Board issued Physician's and Surgeon's Certificate No. G 45851 to Vincent Paul Kater, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on April 30, 2019, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . . ."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more

than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, D, and E, as more particularly alleged hereinafter:

PATIENT A

9. According to respondent's certified medical and billing records, respondent first started treating Patient A, a then-32-year old female, in approximately June 2003, for her primary health care needs.[1] The patient's prior medical history included anxiety, depression, post-traumatic stress disorder, arising from a prior abusive marriage, fibromyalgia, systemic lupus, chronic migraine headaches, and complaints of pain. Respondent continued his care and treatment of Patient A and over time she was also seen by various other specialists. After awhile, patient A was tried on several different pain medications, including fentanyl, hydromorphone, hydrocodone, and oxycodone, mostly under the guidance of the pain management specialist. Beginning in at least 2005, respondent treated patient A's mental symptoms with different psychiatric medications including, but not limited to, Venlafaxine, Seroquel, Lyrica, Buspar and

[1] Conduct occurring more than seven (7) years from the filing date of this First Amended Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

Xanax. Starting in approximately 2006, respondent started prescribing Xanax on a near monthly basis with the dosage being increased over time from 0.5 mg to 1.0 mg and the quantity being increased from #60 to #90. Respondent had hospital admissions on November 17, 2008, for the treatment of "uncontrollable pain involving diffuse muscles and joints, along with migraine headaches... [;]" on November 26, 2008, for back pain; and December 9, 2008, for weakness followed by abdominal pain, nausea and vomiting.

10. On or about January 6, 2009, respondent's husband called to report that he was trying to get patient A into the Mayo Clinic in Scottsdale, Arizona, and requested a copy of her medical records be faxed to the clinic.

11. On or about January 16, 2009, respondent received correspondence from Aetna, as part of their "Aetna Rx Check drug utilization program [which] reviews patients' medication therapies and informs physicians of the potential misuse of certain medications," which warned him that patient A, under her former name, was receiving prescriptions for alprazolam (Xanax)[2] from other physicians. Respondent reviewed the correspondence and noted "put in chart R [right] side."

12. On or about March 2, 2010, respondent received correspondence from Aetna, as part of their "Aetna Rx Check drug utilization program," which, once again, warned him that patient A was receiving prescriptions for alprazolam (Xanax) from other physicians. Respondent reviewed the correspondence and instructed his staff to "put in her chart at the front." Respondent continued to prescribe patient A alprazolam (Xanax) (#90).

13. On or about September 8, 2010, patient A called respondent's office and requested Xanax. According to a chart note, patient A was "crying and asking for her meds" and she reported her "anxiety is out of control desperately" and she needed Xanax "ASAP!"

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[2] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

14. On or about September 11, 2010, patient A was admitted to Alvarado BHS for severe anxiety and depression and for "detoxification." Her admission diagnoses were listed as major depression, recurrent; anxiolytic dependence, opioid dependence, and anxiety disorder NOS (not otherwise specified). Specific problems addressed during patient A's admission to Alvarado BHS included, but were not limited to, "out of contact with reality, alteration in mood/depressed, substance abuse, [and] chronic pain management..." Patient A was stabilized and discharged on September 16, 2010, to an outpatient recovery treatment center.

15. On or about October 11, 2010, respondent received correspondence from Aetna, as part of their "Aetna Rx Check drug utilization program," which, once again, warned him that patient A was receiving prescriptions for alprazolam (Xanax) from other physicians.

16. On or about October 21, 2010, respondent attempted to terminate his physician-patient relationship with patient A by sending her a certified letter which stated, in pertinent part:

> "There appears to be a breakdown in confidence, trust and communication that is essential for a physician patient relationship. This is due to you getting tranquilizers from several doctors. Accordingly, this letter is to advise you that I am terminating our relationship. I shall not be able to attend [to] you after November 5, 2010. I will be available during these 15 days for emergency treatment and for prescriptions requests.
>
> ". . . ."

17. On or about December 8, 2010, respondent received a consultation report from Dr. H.K., a board certified psychiatrist, who diagnosed patient A as suffering from Attention Deficit Hyperactivity Disorder (ADHD) Combined Type, Obsessive Compulsive Disorder (OCD), Panic Disorder and Opiate Dependence. Among other things, Dr. H.K. recommended "... reducing and stopping Xanax and adjusting her Subutex and Lunesta, and possibly changing her Effexor, consider adding medicine for her Attention Deficit." At or around this time, respondent stopped prescribing Xanax to patient A.

18. Beginning in November 2010, respondent began treating patient A again and continued to see her every few months.

19. On or about November 29, 2011, patient A was admitted to Sharp Grossmont Hospital emergency department "secondary to a suicidal attempt." According to available

medical records, patient A's estranged husband called the Sheriff's Department after patient A texted him that she was going to overdose on Xanax. Subsequently, the estranged husband observed patient A take a handful of Xanax and patient A admitted to a registered nurse at Sharp Grossmont Hospital that she had taken eight (8) Xanax. Patient A was transferred from the emergency department on November 30, 2011, to a "behavioral health unit facility for further management."

20. On or about August 16, 2012, respondent resumed prescribing alprazolam (Xanax) 2 mg (#60) to patient A. The chart note for this date indicates, among other things, "Xanax 2/60 bid [2 tablets per day] – agree for one month only."

21. According to respondent's certified medical records, respondent continued to prescribe Xanax to patient A after August 16, 2012, and increased the dosage of Xanax 2 mg from (#60) to (#90) on December 20, 2012. Respondent's chart notes for December 20, 2012, indicate, in pertinent part, "Xanax 2/90 – while trying to stop smoking." Respondent's handwritten chart notes during 2012 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions.

22. During the period of January 1, 2013, to November 29, 2013, respondent had nine (9) visits with patient A. According to respondent's chart notes, the visits took place on January 21, March 5, April 12, May 13, June 11, August 6, September 30, October 28 and November 25, 2013. According to respondent's chart notes, patient A's problems during 2013 generally included, but were not limited to, anxiety and depression with occasional references to chronic pain, ADD, lupus, fibromyalgia. Respondent's handwritten chart notes during 2013 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. According to the Controlled Substances Utilization and Evaluation System (CURES) report over this period of time, patient A filled, among other things, twelve (12) prescriptions of alprazolam (Xanax) 2 mg (#90) issued by

respondent and thirteen prescriptions of Lyrica primarily 300 mg at quantities that varied between (#60) and (#90).[3]

23. On or about October 5, 2013, patient A was admitted to Sharp Grossmont Hospital after she overdosed on her pain medication, Opana.

24. On or about November 30, 2013, patient A was found dead in her bed from an apparent suicide by overdose. The official cause of death was listed as "acute oxymorphone intoxication and acetaminophen intoxication."

25. Respondent committed gross negligence in his care and treatment of patient A which included, but was not limited to, the following:

(a) Respondent failed to appreciate the danger associated with the concomitant use of benzodiazepines and opiate medications and increased the risk of harm to respondent when he resumed his prescribing of alprazolam (Xanax) beginning in August 2012 until the time of her death; and

(b) Respondent continued to prescribe Lyrica to patient A despite the increased risk of suicide associated with Lyrica.

PATIENT B

26. On or about December 9, 2005, respondent began treating patient B, a then-57-year old male with a self-reported history which included, among other things, lower back disc surgery in 1981, high blood pressure, arthritis and joint problems, back problems, emotional and psychological problems, positive family history for "emotional disorder" and a problem with alcohol in the past. Patient B indicted he was under the care of a psychiatrist for generalized anxiety disorder and attention deficit disorder and listed his current medications as clonazepam (Klonopin), Cymbalta and Restoral. Following respondent's first visit, he prescribed patient B,

[3] Lyrica® (pregabalin) is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, Lyrica® is used for, among other things, the treatment of neuropathic pain associated with spinal cord injury and/or the management of fibromyalgia or seizures. Caution must be exercised when prescribing Lyrica® to patients with a history of depression, suicidal thoughts, drug and/or alcohol addiction.

among other things, Vicodin[4] and Viagra. During the period of 2006 through 2010, respondent continued to treat patient B and prescribed various controlled substances including, but not limited to, Vicodin, Adderall[5] and clonazepam (Klonopin).[6]

27. During the period of on or about January 1, 2011, to December 31, 2011, respondent had four visits with patient B. According to respondent's chart notes, the visits took place on March 25, June 21, September 15, and December 5, 2011. According to respondent's chart notes, patient B's problems during 2011 generally included, but were not limited to, back pain, neck pain and attention deficit disorder. Chart notes for June 21, 2011, documented that a Von's pharmacist reported patient B was acting erratically and angry, was accusing the pharmacy of

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[4] Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

[5] Adderall®, a mixture of d-amphetamine and l-amphetamine salts in a ratio of 3:1, is a central nervous system stimulant of the amphetamine class, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for attention-deficit hyperactivity disorder and narcolepsy. According to the DEA, amphetamines, such as Adderall®, are considered a drug of abuse. "The effects of amphetamines and methamphetamine are similar to cocaine, but their onset is slower and their duration is longer." (Drugs of Abuse – A DEA Resource Guide (2011), at p. 44.) Adderall and other stimulants are contraindicated for patients with a history of drug abuse.

[6] Klonopin® (clonazepam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used to treat seizure disorders and panic disorders. The maximum daily dose of Klonopin® is generally not to exceed 4 mg per day. Concomitant use of Klonopin® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Klonopin®, as drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

"shorting his meds," and that he "proceeded to curse at staff and was kicked out of store without having Rx refilled." Respondent's handwritten chart notes during 2011 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2011, respondent issued at least five prescriptions of, among other things, clonazepam (Klonopin) 2 mg (#200), five prescriptions of Vicodin 5/500 mg (#150), four prescriptions of MS Contin (morphine sulfate)[7] 60 mg (#90) and four prescriptions of Adderall XR 30 mg (#90) and four prescriptions of Adderall 10 mg (#90).

28. During the period of on or about January 1, 2012, to December 31, 2012, respondent had four visits with patient B. According to respondent's chart notes, the visits took place on March 5, May 29, August 13, and November 5, 2012. On February 12, patient B called requesting a prescription of MS Contin and stated that he just needed 3 pills because "he will have withdrawals if [respondent] does not give him today." According to respondent's chart notes, patient B's problems during 2012 generally included, but were not limited to, back pain, chronic pain and attention deficit disorder. Respondent's handwritten chart notes during 2012 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2012, respondent issued at least four prescriptions of, among other things, clonazepam (Klonopin) 2 mg (#200), four prescriptions of Vicodin 5/500 mg (#150), four prescriptions of MS Contin (morphine sulfate) 60

[7] MS Contin® (morphine sulfate), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of pain that is severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. The Drug Enforcement Administration has identified MS Contin®, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 39.) The Federal Drug Administration has issued a black box warning for MS Contin® which warns about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warning also cautions about the risks associated with concomitant use of MS Contin® with benzodiazepines or other central nervous system (CNS) depressants.

mg (#150); four prescriptions of Adderall XR 30 mg (#90) and two prescriptions of Adderall 10 mg (#90).

29. During the period of on or about January 1, 2013, to December 31, 2013, respondent had four visits with patient B. According to respondent's chart notes, the visits took place on February 5, May 2, August 1, and October 31, 2013. On May 13, a handwritten chart note indicated that patient B's blood test results were all good with the exception of an issue with the patient's liver with respondent recommending that the patient "drink less alcohol, avoid Tylenol and [re-check] in 3 months."[8] A chart entry of October 31, 2013, indicated that patient B fell off a ladder two weeks ago trimming a tree and went to the hospital. According to respondent's chart notes, patient B's problems during 2013 generally included, but were not limited to, lower back pain, chronic pain and attention deficit disorder. Respondent's handwritten chart notes during 2013 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2013, respondent issued at least four prescriptions of, among other things, clonazepam (Klonopin) 2 mg (#200), two prescriptions of Vicodin 5/500 mg (#150), four prescriptions of MS Contin (morphine sulfate) 60 mg (#150); two prescriptions of Norco 5/325 mg (#150) [with no explanation in the chart notes as to why Vicodin was discontinued and Norco was started], four prescriptions of Adderall XR 30 mg (#30) [with no explanation in the chart notes as to why the amount of Adderall was being reduced].

30. During the period of on or about January 1, 2014, to December 31, 2014, respondent had six visits with patient B. According to respondent's chart notes, the visits took place on January 27, February 11, April 22, July 22, October 20, and December 5, 2014. On April 22, 2014, respondent's chart notes indicate "weaning Adderall down to 10 q.d. [10 mg per day] we discussed meds [and] ways to do it." According to respondent's chart notes, patient B's problems during 2014 generally included, but were not limited to, lower back pain, chronic pain, attention

[8] On a personal history form of December 9, 2005, patient B self-reported that he previously had problems with alcohol and that he no longer drank alcohol.

deficit disorder, with some cursory references to anxiety and fatigue. Respondent's handwritten chart notes during 2014 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2014, respondent issued at least four prescriptions of, among other things, clonazepam (Klonopin) 2 mg (#200), two prescriptions of Vicodin 5/500 mg (#150), three to four prescriptions of MS Contin (morphine sulfate) 60 mg (#90); four prescriptions of Norco 5/325 mg (#150), and three prescriptions of Adderall 10 mg (#30).

31. During the period of on or about January 1, 2015, to July 1, 2015, respondent had three (3) visits with patient B. According to respondent's chart notes, the visits took place on January 9, March 20, and June 16, 2015. According to respondent's chart notes, patient B's problems during 2015 generally included, but were not limited to, chronic pain, attention deficit disorder, and anxiety. During 2015, respondent continued to wean patient B off of the Adderall 10 mg with a chart note of June 16, 2015, indicating "he plans of stopping this [Adderall 10 mg] altogether." Respondent also charted on June 16, 2015, "wean Klonopin as able." Respondent's handwritten chart notes during 2015 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. According to CURES, during the time frame of January 1, 2015, to July 1, 2015, Patient B filled the following prescriptions from respondent: three prescriptions of morphine sulfate 60 mg (#90); three prescriptions of hydrocodone/APAP (Norco)5/325 mg (#150); three prescriptions of Adderall 10 mg (#60); and four prescriptions of clonazepam (Klonopin) 2 mg (#60).

32. Respondent committed gross negligence in his care and treatment of patient B which included, but was not limited to, the following:

(a) Respondent primarily relied on opioids to treat patient B's alleged pain and failed to adequately consider safer non-opioid based treatment options for the treatment of patient B's alleged pain.

PATIENT C

33. On or about January 18, 2005, respondent started treating patient C, a then-45-year old female with a history of lumbar spine and cervical spine fusion surgery in 1999. As part of the initial visit, respondent obtained a release from patient C for her medical records from [M.V.] Medical Clinic, which were received a few days later. Respondent conducted a physical examination and ordered labs. According to respondent's chart note for January 18, 2005, respondent's assessment included, but was not limited to, chronic neck and back pain, depression, gastroesophageal reflux disease (GERD), hyperthyroidism, and anemia.

34. During the period of 2003 through 2010, patient C was treated by respondent and seen by various other specialists. In late 2010, respondent referred patient C to Dr. W.W., a pain management specialist, for evaluation and consultation. At the time of her evaluation, patient C's pain medications were listed as hydrocodone/APAP 10/325 mg (12 tablets a day) and OxyContin (oxycodone HCL) 80 mg (3 tablets three times a day) for a combined morphine milligram equivalency (MME) dose of 1,200 mg per day. Dr. W.W.'s impression was left lumbar facet pain, left anterior thigh pain, possible radicular symptom, and possible analgesic hyperalgesia (increased pain or hypersensitivity associated with chronic use of opioids) and his recommendation was to maintain patient C on the OxyContin 80 mg 3 tablets t.i.d. for two weeks, hydrocodone/APAP (Norco) 10/325 mg 6 tablets q.d. (per day), urine drug screen and consultation with another physician, Dr. J.R.

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35. On or about November 16, 2010, Dr. W.W., who had just seen patient C, for a pain management consultation, sent correspondence to respondent which stated, as follows:

"Dear Dr. Kater:

"I got a call from [patient C] on November 9 saying she didn't want to see me, but would be getting her medications from you until she was seen elsewhere. I suspect she was unhappy with the fact that I referred her to Dr. [J.R.] who helps me sort out complex analgesic problems. [Patient C], as you know, is requiring very large doses over many years. She is also vague about her history and everything on physical exam produced pain. One medical explanation for this is analgesic hyperalgesia, when pain meds are causing increased pain rather than giving pain relief. The more common explanation is some behavioral/drug issue. Dr. [J.R.] is very good at sorting out these issues and also very good at developing a working rapport with even (sic) patients, whatever the underlying problem.

"I'm writing to suggest caution with [patient C] and to suggest the kind of assistance I was seeking from Dr. [J.R.]

"I'm sorry I couldn't make any progress with her."

36. During the period of on or about January 1, 2011, to December 31, 2011, respondent had thirteen visits with patient C. According to respondent's chart notes, the visits took place on January 4, February 1, March 1, March 29, April 26, May 20, June 20, July 18, August 15, September 12, October 10, November 7 and December 1, 2011. According to respondent's chart notes, patient C's problems during 2011 generally included, but were not limited to, hyperthyroidism and chronic pain. On February 4, 2011, patient C was seen for a consultation with Dr. M.E., who was board certified in physical medicine and rehabilitation and pain management who recommended that patient C see another physician, Dr. N.T., who in her opinion, was the "most qualified to help her & can offer additional pain management options." Respondent's chart notes of March 2, 2011, indicated, in pertinent part, "[Dr. M.E.] referred to [Dr. N.T.] [patient C] has been unable to get in to see [Dr. N.T.]" On April 15, patient C reported "her Norco got stolen out of her purse" and another prescription was approved for her. On April 28, a chart note indicated patient C "stated she would not be able to provide urine [sample] because she will be heading out of town" with a note from respondent stating "next visit then."[9] On July 18, chart notes indicated the plan was to reduce OxyContin to eight per day. On May 13,

[9] A urine sample was collected at the next visit of May 18, 2012, which tested negative for hydrocodone/APAP (Norco) despite the fact that patient C was being prescribed Norco.

a chart note documented an early refill. On September 23, patient C requested that a prescription of Ambien be called into the pharmacy and she was provided with a prescription for Ambien 10 mg prn (as needed) for insomnia. Respondent's handwritten chart notes during 2011 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2011, respondent maintained patient C on, among other things, monthly prescriptions of hydrocodone/APAP (Norco) 10/325 (#180) mg and OxyContin 80 mg (#270) for a combined MME of 1,080 mg per day.

37. During the period of on or about January 1, 2012, to December 31, 2012, respondent had fifteen visits with patient C. According to respondent's chart notes, the visits took place on January 20, February 2, February 24, March 22, April 19, May 18, June 14, July 12, August 7, September 4, September 17, October 2, October 29, November 26 and December 21, 2012. According to respondent's chart notes, patient C's problems during 2012 generally included, but were not limited to, chronic pain, hyperthyroidism, occasional panic attacks and bronchitis. Chart notes of October 2, 2011, indicate "we discussed [illegible] pain med – [alternate] 8-9 OxyContin." Chart notes of November 24, 2012, indicated "[decrease] [medication] as able..." Respondent's handwritten chart notes during 2012 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2012, respondent maintained patient C on, among other things, near monthly prescriptions of hydrocodone/APAP (Norco) 10/325 (#180) mg and OxyContin 80 mg (#270) for a combined MME of 1,080 mg per day. According to CURES, patient C filled fourteen prescriptions of OxyContin 80 mg (#270) and 14 prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#180) from respondent during 2012.

38. During the period of on or about January 1, 2013, to December 31, 2013, respondent had thirteen visits with patient C. According to respondent's chart notes, the visits took place on January 10, February 14 (seen by another physician), March 26, April 22, May 20, June 17, July 12, August 9, September 3, October 3, October 28, November 25, December 20 and December

23, 2013. According to respondent's chart notes, patient C's problems during 2013 generally included, but were not limited to, chronic pain, hyperthyroidism, with some notations of bronchitis and depression/anxiety. On March 18, 2013; patient C requested that a prescription of Xanax be called in for her and respondent called in a prescription for Xanax 0.5 mg (#30) p.r.n. anxiety. Chart notes of March 26, 2013, indicate "tomorrow for injections in back [M.V.] Pain Management." Chart notes of June 21, 2013, indicate "Norco and Xanax not found in urine" despite the fact that respondent had been prescribing both of the controlled substances to patient C. Chart notes of August 9, 2013, indicate "use of narcotics discussed." On November 11, 2013, there was codeine found in patient C's urine with chart notes indicating "will [check] with patient C next visit."[10] Respondent's handwritten chart notes during 2013 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2013, respondent maintained patient C on, among other things, near monthly prescriptions of hydrocodone/APAP (Norco) 10/325 (#180) mg and OxyContin 80 mg (#270) for a combined MME of 1,080 mg per day; with occasional prescriptions of Xanax 0.5 mg.[11]

39. During the period of on or about January 1, 2014, to December 31, 2014, respondent had sixteen visits with patient C. According to respondent's chart notes, the visits took place on January 17, February 11, March 6, April 4, April 25, May 19, June 13, July 15, August 8, September 8, October 2, October 27, November 18, November 23, December 11, and December 29, 2014. Chart notes of January 20 and 21, 2014, indicate patient C was upset because respondent's office did not initiate price authorization for her OxyContin. According to respondent's chart notes, patient C's problems during 2014 generally included, but were not

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[10] A urine sample collected on October 28, 2013, detected an unexplained codeine analyte and failed to detect any sign of the Norco and Xanax that was being prescribed to patient C.

[11] According to CURES, patient C filled thirteen prescriptions of OxyContin 80 mg (#270); one prescription of OxyContin 80 mg (#120); nine prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#180) and three prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#90) from respondent during 2013.

limited to, chronic pain, depression, bronchitis, and occasional depression, anxiety and panic attacks. On January 31, 2014, patient C called requesting codeine cough syrup with respondent documenting in his chart that "already taking narcotics, extra codeine won't help." On February 11, 2014, patient C requested early refill of her OxyContin because she was heading out of town.[12] On June 16, 2014, respondent's office received a call from a CVS pharmacist advising respondent's office that patient C was seeking early refills of Norco and OxyContin. Respondent's handwritten chart notes during 2014 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2014, respondent maintained patient C on, among other things, near monthly prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#180) and OxyContin 80 mg (#270) for a combined MME of 1,080 mg per day; with occasional prescriptions of Xanax 0.5 mg.[13]

40. During the period of on or about January 1, 2015, to July 2015, respondent had eleven visits with patient C. According to respondent's chart notes, the visits took place on January 22, February 22, March 17, March 20, March 26, April 7, April 10, May 7, May 12, June 4, and June 16, 2015. According to respondent's chart notes, patient C's problems during 2015 generally included, but were not limited to, chronic pain, GERD, hypothyroidism, and occasional bronchitis. On January 26, 2015, respondent's office received a call from a pharmacist advising that patient C was requesting an early refill of Norco and OxyContin with respondent approving the early refill. Chart notes of May 15, 2015, indicate patient C called and "said she is allowed to have pain patch...not sure of which one to get" with respondent documenting "OK to pick up Rx [-] how many days will she need it for?" A CURES entry for May 20, 2015, indicates a

[12] Other chart notes of February 11, 2014, indicate "Spoke with [N] pharmacist @ pharmacy. He ok'd refill of Norco but said OxyContin is 11 days early and will not fill it barring some major DX [diagnosis] like cancer."

[13] According to CURES, patient C filled fourteen prescriptions of OxyContin 80 mg (#270) and fourteen prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#180) from respondent during 2014.

prescription was filled on that date for a Fentanyl patch[14] 100 mcg/hour for 72 hours. The addition of the fentanyl patch increased patient C's morphine milligram equivalency (MME) from an already alarmingly high of approximately 1,080 mg per day to 1,380 mg per day. There is nothing documented in respondent's chart notes as to the medical necessity for the Fentanyl patch. On June 4, 2015, patient C told respondent she lost her OxyContin. The chart notes of June 4, 2014, indicate "long discussion loss of [medication] – last occurred 4 years ago. Dangers of narcotics against discussed. Need to wean as able." On June 10, 2015, respondent received a written note from a third party advising him, in pertinent part, that "I'm writing you to let you know that [patient C] has been selling pills for years..." and that she had a "side business." Chart notes of June 11, 2015, indicate "told [patient C] I can no longer give her narcotics as she was seen selling them [-] will give her names of pain specialists [with a list of integrated pain management specialists]." On June 16, 2015, respondent had an office visit with patient C who denied selling her medications as reported. Chart notes of June 16, 2015, indicate "I will give her this one last refill to her time to find a doctor to give her [medications]." Respondent's handwritten chart notes during 2015 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. According to CURES, patient C filled seven prescriptions of OxyContin 80 mg (#270); six prescriptions of hydrocodone/APAP (Norco) 10/325 mg (#180); and one prescription of Fentanyl patch 100 mcg/hour for 72 hours from January 1 through July 1, 2015.

41. Respondent committed gross negligence in his care and treatment of patient C which included, but was not limited to, the following:

[14] Fentanyl transdermal (Duragesic®) patches are a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated fentanyl transdermal patches are indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

(a) Respondent failed to properly manage and/or monitor the opioids that were being prescribed to patient C which included, but was not limited to, failing to recognize indications of misuse or diversion, failing to taper or rotate opioids as recommended and failing to prescribe opioid antidote.

PATIENT D

42. On or about June 1, 2007, respondent started treating patient D, a then-48-year old male with a self-reported history of high blood pressure, arthritis/joint problems, back problems and adult ADHD/ADD. Patient D listed his current medications as including, but not limited to, Adderall 20 mg, OxyContin 80 mg (#90), Dilaudid 8 mg (#120), and Viagra. Chart notes for the initial visit indicate "(1) ADHD, (2) pain on [right side] due to injury [and] (3) refills" and reference made to "pain [management doctors] @ Kaiser – stable on regimen." The chart notes for the initial visit fails to document any detailed physical examination. Respondent's assessment was ADHD and back, knee, hip and leg pain. The plan, as documented in the chart notes, was "OK to refill meds [-] records [-] [re-check one month]." The chart notes for the next visit, June 26, 2007, indicate "[patient D] said he had sent away for records, 2 [weeks] ago." There were no prior medical records located in the certified medical records produced to the Medical Board by respondent.

43. On or about October 12, 2007, respondent's office received a call from a pharmacy indicating that "[patient D] filled prescription from you on October 9, 2007 for oxycodone [and] brought in another Rx date 10/9/07 for same Rx today. Pharmacist wants to know if you wrote 2 Rx's." The chart notes for this date indicate that respondent spoke with the pharmacist and [patient D] and "he is to get further refills at pain specialist – no more refills from this office." Chart notes for December 3, 2007, indicate "names given to pain specialist OK to refills meds." On February 12, 2008, there were further discussions with patient D about not following respondent's prescribing schedule.

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44. On or about December 10, 2009, respondent sent a letter to patient D which advised him that he would no longer be writing him prescriptions for "chronic narcotics." The letter stated, in pertinent part:

> "I will no longer write prescriptions for chronic narcotics. These medications can more appropriately be continued through a chronic pain clinic. Names, addresses, and phone numbers of several local pain specialists are attached in this letter. I can send a referral to [a] specialist of your choice. Appointments should be made soon, as it often takes several weeks to initially see these doctors. I will continue to refill medications until you are seen by the pain specialist, but in no event will that continue beyond February 28, 2010. [¶] I will continue to be available for all other medical issues."

45. Despite sending the letter of December 10, 2009, and indications of patient D continuing to refill his medications early, respondent continued to refill patient D's prescriptions including Oxycodone 30 mg (#360) which continued through October 25, 2010, at which point the prescriptions of Oxycodone 30 mg continued on a near monthly basis but the monthly quantity was decreased to (#120) for November 15, 2010, and then increased to (#240) for December 2010.[15]

46. During the period of on or about January 1, 2011, to December 31, 2011, respondent had sixteen visits with patient D. According to respondent's chart notes, the visits took place on January 3, January 21, February 7, February 28, March 17, April 12, May 6, June 16, July 7, July 20, August 19, September 21, October 20, November 15, December 9, and December 29, 2011. According to respondent's chart notes, patient D's problems during 2011 generally included, but were not limited to, chronic pain and ADD. Chart notes of February 28, 2011, state "dangers of narcotics discussed [-] continue to advocate for pain specialist [-] continue to wean meds until he gets pain specialist." Respondent's handwritten chart notes during 2011 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2011, respondent maintained patient D on, among

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[15] Respondent's chart notes for August 30, 2010, indicate "moving to Israel, if not – to pain specialist [-] OK to refill."

other things, Oxycodone 30 mg (#240 – MME 360 mg/day) from January which was gradually tapered down to (#190 – MME 285 mg/day) in September. On October 20, 2011, respondent began prescribing methadone 10 mg (#90) and reduced the Oxycodone 30 mg to #150 which resulted in an increase of the MME from 285 mg/day to 465 mg/day. There was no explanation in respondent's chart note of October 20, 2011, for the addition of methadone which resulted in a sixty-three (63) percent increase in the MME for patient D. Moreover, the introduction of methadone increased the risk for fatal cardiac arrhythmias with no apparent EKG monitoring taking place.

47. During the period of on or about January 1, 2012, to December 31, 2012, respondent had fifteen visits with patient D. According to respondent's chart notes, the visits took place on February 2, February 29, March 26, April 20, May 18, June 14, July 9, August 31, September 24, October 18, November 9, October 18, November 9, November 30, and December 21, 2012. According to respondent's chart notes, patient D's problems during 2012 generally included, but were not limited to, chronic pain (with indications of knee pain), HTN (hypertension), ADD, and occasional depression. Respondent's handwritten chart notes during 2012 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. Respondent maintained patient D on, among other things, Oxycodone 30 mg (#150) and methadone 10 mg (#90) [combined MME of 465 mg/day] from January 1, 2012, through November 29, 2012. On November 30, 2012,[16] respondent increased the Oxycodone 30 mg to (#180) and continued the methadone 10 mg (#90) which increased the MME for patient D from 465 mg/day to 510 mg/day.

48. During the period of on or about January 1, 2013, to December 31, 2013, respondent had fourteen (14) visits with patient D. According to respondent's chart notes, the visits took place on January 17, February 11, March 8, April 2, April 23, May 16, June 13, July 11, August

[16] The chart notes for November 30, 2012, indicate that "weather makes pain much worse...[treatment] options [and] need to control medications...[assessment] OA [osteoarthritis] knee [and] [plan] if pain continues severely, to pain specialist... [increase] oxycodone to 180 (6/d) [six per day]."

6, August 30, October 17, November 7, and December 2, December 30, 2013. According to respondent's chart notes, patient C's problems during 2013 generally included, but were not limited to, alleged chronic pain, HTN, ADD, GERD, and occasional chest pain. On May 16, 2013, after experiencing repeated problems with early refills, respondent entered a chart note which stated "warned re: last early refill [-] will sign affidavit @ [illegible] visit re early refill [-] next refill not before [June] 13." Respondent's handwritten chart notes during 2013 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions. During 2013, according to respondent's medical records, respondent maintained patient D on, among other things, Oxycodone 30 mg on a near monthly basis, in fluctuating quantities, [17] and methadone 10 (#90). The MME for patient D at the end of 2013 was 510 mg/day.

49. During 2014, respondent had one visit with patient D which took place on January 23, 2014. The chart notes for this visit indicate, among other things, "last early refill" and "I will not give a refill prior to [February 21] under any circumstances." On January 29, 2014, respondent received a telephone message from a San Diego Police Department detective regarding patient D and his girlfriend with a request to "please call when you get in." A handwritten note of the same date states, "gave [message] to M.D." There are no chart notes as to the nature of the call, if any, between respondent and the detective. Chart notes of January 30, 2014, state "Spoke with patient – no further controlled substances will be given." Respondent's handwritten chart notes during 2015 were generally cursory, lacked adequate detail, failed to set forth goals of treatment including efficacy and functional improvement, failed to document appropriate physical examinations, and/or failed to provide a clear rationale for medical decisions.

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[17] Respondent's medication flow sheet lists the following quantities beginning in January 2013, through the end of the year: #180 (three sequential prescriptions), #160, #150, #160, #160, #100 (three sequential prescriptions), #160, #160, and #180 (four sequential prescriptions).

50. Respondent committed gross negligence in his care and treatment of patient D which included, but was not limited to, the following:

(a) Respondent increased the risk of harm to patient D when he prescribed oxycodone 30 mg in combination with methadone 10 mg and failed to conduct adequate cardiac monitoring.

PATIENT E

51. On or about 2001, respondent began his care and treatment of patient E, a then-89-year-old-woman with a history of, among other things, osteoarthritis, urinary incontinence, macular degeneration and mild cognitive impairment with probable Alzheimer's disease.

52. On or about February 23, 2001, patient E had foot bunion surgery (a bunionectomy) and was prescribed an opiate based pain medication for management of her post-operative pain.

53. On or about February 25, 2001, patient E suffered a loss of consciousness during dinner with family and was observed not breathing. Family members performed CPR on patient E and she was revived. The paramedics were called and transported patient E to the hospital, where she was admitted for further observation. While at the hospital, patient E was examined by respondent, as her attending physician, who was aware of the incident she experienced after taking "Vicodin at home." Patient E was discharged the next day in stable condition and respondent continued to provide primary care to patient E, over which time patient E's Alzheimer's disease progressively worsened.

54. Beginning on or about April 2007, respondent treated patient E on several occasions for shortness of breath and night-time breathing difficulties (orthopnea) and leg edema. On January 19, 2009, respondent signed a California Department of Social Services' Physician's Report for Residential Care Facilities for the Elderly (RCFE) form, as part of patient E's transition into B.G., a residential care facility, which indicated, among other things, that patient E was allergic to Vicodin and Penicillin. Patient E's diagnoses at time of admission to the residential care facility on January 30, 2009, were listed as dementia and history of urinary tract infections. Respondent continued to provide primary care to patient E while she was at the residential care facility.

55. On or about December 14, 2010, respondent executed another California Department of Social Services' Physician's Report for Residential Care Facilities for the Elderly (RCFE) form which, once again, indicated that patient E was allergic to Vicodin and Penicillin.

56. On or about February 19, 2014, respondent's office received a call from the residential care facility advising them that patient E had fallen. A request was made for pain medication to be called into the pharmacy for patient E and for x-rays of patient E's hip.

57. On or about February 20, 2014, arrangements were made for x-rays of both hips and respondent, without reviewing patient E's charts, [18] which indicated patient E was allergic to Vicodin, a hydrocodone/acetaminophen (APAP) product, called in a prescription for hydrocodone/APAP (Norco) 5/325 mg #30 every six hours as needed for pain. Patient E's daughter picked up the prescription of Norco the same day and gave her mother, patient E, one tablet of the Norco with her lunch at approximately noon and then left the residential care facility. As approximately 12:20 p.m., patient E's daughter received a call from the residential care facility advising that her mother, patient E, was in distress. Patient E's daughter pulled her car over and read the paperwork for the Norco prescription, at which point she realized that Norco had the same active ingredients as Vicodin, for which her mom had a known drug allergy. Patient E's daughter immediately called respondent's office to report that her mom had an adverse reaction to the Norco. The chart notes for patient E, filled out by a staff member, indicate "[patient] had a[n] adverse reaction to Norco, [patient] was vomiting and her eyes rolling back..." According to patient E's daughter, when she attempted to speak with respondent, a staff member told her he was currently with patients. When patient E's daughter explained the situation to the

[18] The certified medical records for patient E contain various references to patient E being allergic to Vicodin, a hydrocodone/APAP product, which include, but are not limited to, the outside of respondent's three volumes of medical records each containing a warning stamp indicating "Drug Allergies[;] PCN [penicillin] [and] Vicoden [sic] – stopped breathing[;]" a type-written chart note dated April 24, 2007, prepared by K.D., a physician assistant student, and initialed by respondent, which states "PCN-hives, Vicodin-apnea[;]" "Medication Schedule/Instructions" from patient E's residential care facility indicating that patient E had drug allergies which included penicillin and hydrocodone/APAP (Vicodin), some of which were initialed by respondent; and at least two California Department of Social Services' Physician's Report for Residential Care Facilities for the Elderly (RCFE) forms, that were signed by respondent.

staff member, the staff member told her there was a notation on the outside of the chart indicating that Vicodin (a hydrocodone/APAP product) could cause the patient to stop breathing. Upon being advised of patient E's adverse reaction to the Norco, respondent discontinued the Norco and called in a prescription for Tramadol, a different and less-potent pain reliever. The chart notes for February 20, 2014, include a handwritten notation from respondent indicating "stop [N]orco [-] [T]ramadol 50 #30 1-2 q.i.d. [four times a day] prn [as needed for] pain." According to respondent's chart notes, patient E's daughter was advised that the Norco was discontinued and a new prescription was called in for Tramadol. According to patient E's daughter, and D.J., the owner and administrator of the residential care facility, several calls were made to respondent requesting to speak to him, but there was no call back from respondent and respondent did not personally check on patient E at the residential care facility.

58. On or about February 21, 2014, respondent's office received a call from patient E's daughter reporting that her mother, patient E, was "not doing well." The residential care facility also called requesting "hospice order asap [-] [patient E] not doing well." Patient E passed away on February 21, 2014, at 11:50 a.m. When patient E's daughter arrived home later that day, she retrieved a message from respondent that was left at 12:10 p.m. that day with respondent indicating he hoped her mother was okay.

59. Respondent committed gross negligence in his care and treatment of patient E which included, but was not limited to, the following:

(a) Respondent prescribed hydrocodone/APAP (Norco) to patient E without reviewing patient E's medical records which indicated patient E was allergic to hydrocodone/APAP controlled substances such as Vicodin and Norco;

(b) Respondent failed to use a non-opioid based first line therapy, such as acetaminophens and/or non-steroidal anti-inflammatory drugs (NSAID's), before prescribing patient E hydrocodone/APAP (Norco) which created a greater risk of harm to patient E; and

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(c) Respondent failed to respond in a timely and appropriate manner after receiving the report of patient E's adverse reaction to the hydrocodone/APAP (Norco) that was prescribed to her.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

60. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, D, and E, as more particularly alleged herein.

PATIENT A

61. Respondent committed repeated negligent in his care and treatment of patient A which included, but was not limited to, the following:

(a) Paragraphs 9 through 25, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to appreciate the danger associated with the concomitant use of benzodiazepines and opiate medications and increased the risk of harm to respondent when he resumed his prescribing of alprazolam (Xanax) beginning in August 2012 until the time of her death;

(c) Respondent continued to prescribe Lyrica to patient A despite the increased risk of suicide associated with Lyrica; and

(d) Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of patient A, including the prescribing of controlled substances.

PATIENT B

62. Respondent committed repeated negligent in his care and treatment of patient B which included, but was not limited to, the following:

(a) Paragraphs 26 through 32, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent primarily relied on opioids to treat patient B's alleged pain and failed to adequately consider safer non-opioid based treatment options for the treatment of patient B's alleged pain;

(c) Respondent failed to recognize patient B's elevated addiction risks and failed to adequately monitor patient B's use of controlled substances, including the benzodiazepines and opioids that were being prescribed to him;

(d) Respondent increased the risk of harm to patient B in prescribing high doses of clonazepam (Klonopin) concurrently with opioids and, in failing to seek a psychiatric consultation related to any medical indication for clonazepam (Klonopin); and

(e) Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of patient B, including the prescribing of controlled substances.

PATIENT C

63. Respondent committed repeated negligent in his care and treatment of patient C which included, but was not limited to, the following:

(a) Paragraphs 33 through 41, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to properly manage and/or monitor the opioids that were being prescribed to patient C which included, but was not limited to, failing to recognize indications of misuse or diversion, failing to taper or rotate opioids as recommended and failing to prescribe opioid antidote; and

(c) Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of patient C, including the prescribing of controlled substances.

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PATIENT D

64. Respondent committed repeated negligent in his care and treatment of patient D which included, but was not limited to, the following:

(a) Paragraphs 42 through 50, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent increased the risk of harm to patient D when he prescribed oxycodone 30 mg in combination with methadone 10 mg and failed to conduct adequate cardiac monitoring;

(c) Respondent primarily relied on opioids to treat patient D's alleged pain and failed to adequately consider safer non-opioid based treatment options for the treatment of patient D's alleged pain; and

(d) Respondent failed to maintain adequate and accurate medical records regarding his care and treatment of patient D, including the prescribing of controlled substances.

PATIENT E

65. Respondent committed repeated negligent in his care and treatment of patient E which included, but was not limited to, the following:

(a) Paragraphs 51 through 59, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent prescribed hydrocodone/APAP (Norco) to patient E without reviewing patient E's medical records which indicated patient E was allergic to hydrocodone/APAP controlled substances such as Vicodin and Norco;

(c) Respondent failed to use a non-opioid based first line therapy, such as acetaminophens and/or non-steroidal anti-inflammatory drugs (NSAID's), before prescribing patient E hydrocodone/APAP (Norco) which created a greater risk of harm to patient E; and

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(d) Respondent failed to respond in a timely and appropriate manner after receiving the report of patient E's adverse reaction to the hydrocodone/APAP (Norco) that was prescribed to her.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

66. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing drugs or treatment to patients C and D, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 33 through 50, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

67. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records regarding his care and treatment of patients A, B, C, and D, as more particularly alleged in paragraphs 8 through 49, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 45851, issued to respondent Vincent Paul Kater, M.D.;

2. Revoking, suspending or denying approval of respondent Vincent Paul Kater, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering respondent Vincent Paul Kater, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: February 12, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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